Stephen Petke
Regulatory Affairs Manager
Regulatory and State Government Affairs, B6LPA
CIGNA Legal & Public Affairs

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Routing B6LPA
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.7746
Facsimile 860.226.4693
stephen.petke@CIGNA.com

Mr. Paul Smith
Division of Health Care Finance and Policy
Two Boylston Street, 4th floor
Boston, MA 02116

Re: Massachusetts Health Care Claims Data Submission Proposed Regulation 114.5 CMR 21.00
Comments from CIGNA HealthCare ("CIGNA")

Dear Mr. Smith:

CIGNA supports the Massachusetts Division of Health Care Finance and Policy (DHCFP) and the Massachusetts Health Care Quality and Cost Council (HCQCC) in their efforts to monitor health care cost trends, minimize the duplication of data submissions by payers to state entities, and to promote administrative simplification among state entities in Massachusetts. We also believe that health care information made available to consumers will empower individuals to make sound decisions as they relate to health care. We appreciate the opportunity to provide comments to proposed Regulation 114.5 CMR 21.00 and Appendix A published on the DHCFP website, www.mass.gov/dhcfp.

Information and Data Submission Requirements
Section 21.03 (1) c. states that Health Care Payers shall submit data sets described in section 21.03.(4) on a monthly basis; except that plans with fewer than 2,000 enrolled lives may opt to submit on a quarterly basis upon advance notice to the Division .

I. Monthly claims files are due to the Division by the fifteenth day of the following month. For example, files containing medical claims, pharmacy claims and member eligibility data for services paid during January should be submitted on February 15.
II. Quarterly reports are due on the last day of the month after the calendar quarter closes; for example the report for files containing medical claims, pharmacy claims and member eligibility data for services paid during the first quarter of the calendar year should be submitted by April 30.

CIGNA understands that other states that require similar data files have established filing schedules that allow payers with member populations under 500 to submit annually and payers with member populations under 50 to submit voluntarily. To avoid undue DHCFP processing costs and payer

file preparation costs, CIGNA recommends that the submission schedule be set as follows:

Total # of Members	*Reporting Period*	*Reporting Schedule*
≥ 2,000	*Monthly*	*Prior to the end of the month following the month in which claims were paid*
500 – 1,999	*Quarterly*	*Prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid*
50 - 499	*Annually*	*Prior to April 30 of the following year for the preceding twelve months in which claims were paid*
< 50	*N/A*	*N/A*

For Health Care Payers with 2,000 or more enrolled lives, the fifteenth day of the following month deadline will not be attainable by CIGNA. The company's systems infrastructure is vast and complex. These systems move millions of rows of data at month-end to transactional data stores and downstream to multiple data marts. In order to assure high quality data, that process requires most of the month. In particular, the process to build facility stays can only be completed after the detailed claim data have been updated and verified. The proposed 15-day deadline allows for negligible quality review of the data before submission. Furthermore, a fifteenth day of the following month deadline would be inconsistent with filing schedules set forth by other states that require similar data files.

Provider Listings
Section 21.03 (4) 1. d. states that Health Care Payers must provide a file that includes standard identifiers such as provider name and locations, and standard identifier codes such as NPI, for hospital based services, ambulatory care, specialty providers and pharmacy providers.

CIGNA desires greater clarity on the selection criteria and parameters of this file. For example, should the file include only providers located in Massachusetts?

Product File
Section 21.03 (4) 1. g. states that Health Care Payers must provide detailed information on covered services, group size, coverage levels, and copayments.

CIGNA desires greater clarity on the selection criteria and parameters of this file. For example, should the file include only plans that correspond to enrollees residing in Massachusetts?

Massachusetts Resident Members and Massachusetts Employer Groups
Section 21.03: (4) b 1. states that Health Care Payers must report health care service claims and encounters for all Massachusetts resident members, and all members of a Massachusetts employer group including

those who reside outside of Massachusetts. *The requirement for data for "members of a Massachusetts employer group" appears to be inconsistent with requirements of many existing data submissions to the Massachusetts Division of Insurance. CIGNA recommends that the "population selection" criteria be clearly defined so that payers may submit information using consistent data parameters. CIGNA recommends that the selection criteria be defined as "Massachusetts resident members or subscribers who receive their benefits under a policy or plan issued in Massachusetts," which is the definition used in 129 CMR 2.05. CIGNA would also appreciate clarification about the value of submitting non-resident data. Much of this information would be duplicative, as CIGNA already submits uniform claims data files to state entities in Maine, New Hampshire and Vermont. The original design of the Vermont Healthcare Claims Utilization & Evaluation System (VHCURES) required non-resident data, but this requirement was later eliminated as the data did not add value to the reporting.*

Schedule A

The company desires greater clarity on the submission schedule set forth in Schedule A. It is difficult to cross reference the Sections of 114.5 CMR 21.00 et seq. In order to avoid confusion, CIGNA would prefer to see the submission schedule set forth in tabular fashion for each of the named files.

CIGNA believes that the October 15, 2010 submission deadline is too aggressive. Our experience with implementations of major requirements such as these proposed regulations suggests that a 9-12 month time line is more realistic. When the company implemented the requirements for 129 CMR 2.00 et seq., full production of submissions was not realized until 10 months after the due date outlined in the regulation. Because of the complexity of it business operations and systems infrastructure, CIGNA's project planning typically requires a minimum 12-month lead time.

Under Schedule A, files described in section 21.03(4) containing claims, member eligibility, provider directory and product information for the period of January 1, 2008 through December 31, 2009 would be due on or before October 15, 2010.

Providing these data files will have a massive impact on CIGNA's available resources. Because of the introduction of new files and changes to existing files, new development and extensive testing will be required for implementation. The company believes that much of the data for eligibility and claims files have previously been provided and re-submission would be largely redundant and costly.

Appendix A

There are 55 new fields on the Medical Claims file. There are 71 new fields on the Eligibility file. Not only will these involve brand new programming, but their inclusion makes both files inconsistent with other states that require similar data files.

Eligibility Data Elements ME035 - ME082 are new fields. Preliminary analysis will need to be conducted to determine where in CIGNA's systems infrastructure these data are housed. It is highly unlikely that these data will be found in reporting data sources. Certain fields such as Deductible Balance and Deductible Used, ME049 and ME050, are only available in claim paying source systems and would not be included in the eligibility file.

Many of the new data elements may not be available in one or more of CIGNA's reporting data sources. These include, but are not limited to the following fields:

MC071 DRG
MC072 DRG Version
MC073 APC
MC074 APC Version
MC075 Drug Code
MC080 Product ID Number
MC081 Reason for Adjustment
MC083 - MC088 ICD9CM Procedure Code 1 - 6
MC090 LOINC Code
MC091 Member PCP ID
MC092 Covered Days
MC093 Non Covered Days
MC094 Patient Status Code
MC095 Coordination of Benefits/TPL Liability Amount
MC096 Other Insurance Paid Amount
MC097 Medicare Paid Amount
MC107 HCPCS Code
MC108 Procedure Modifier - 3
MC109 Procedure Modifier - 4
MC111 Diagnostic Pointer
MC112 Referring Provider ID
MC113 Payment Arrangement Type
MC114 Excluded Expenses
MC115 Medicare Indicator
MC116 Withhold Amount
MC117 Authorization Needed
MC118 Referral Indicator
MC119 PCP Indicator
MC120 DRG Level
MC121 DRG Outlier
MC122 Pseudo Claim
MC123 Denied Flag
MC124 Denial Reason
MC125 Attending Provider
MC126 Accident indicator
MC127 Family Planning Indicator
MC128 Employment Related Indicator
MC129 EPSDT Indicator
MC132 Service Class

ME021 - ME027 Race, Ethnicity
ME033-034 Language
ME035 Health Care Home Assigned Flag
ME036 Health Care Home Number

ME037 Health Care Home Tax ID Number
ME038 Health Care Home National Provider ID
ME039 Health Care Home Name
ME040 Product ID Number
ME044 Member Age Group
ME045 Geocoded Member Address
ME046 Member PCP ID
ME047 Member PCP Effective Date
ME048 Member PCP Termination Date
ME049 Member Deductible Balance
ME050 Member Deductible Used
ME051 Behavioral Health Benefit Flag
ME052 Laboratory Benefit Flag
ME053 Disease Management Enrollee Flag
ME054 Eligibility Determination Date
ME056 Last Activity Flag
ME057 Date of Death
ME059 Disability Indicator Flag
ME060 Employment Status
ME061 Student Status
ME063 Benefit Status
ME064 Employee Type
ME065 Date of Retirement
ME067 Spouse Plan Type
ME068 Spouse Plan
ME069 Spouse Medical Coverage
ME070 Spouse Medicare Indicator
ME071 Pool Indicator
ME073 Risk Type
ME074 Interpreter Flag
ME075 Alternate Identifier
ME076 Member rating category
ME077 SIC Code of Members line of work
ME078 Policy Type
ME079 Recipient ID number
ME080 Recipient Historical Number
ME081 Medicare Code
ME083 Employer EIN

Additional information is also needed on the definition of the following fields before it can be determined if this information is available:
MC111 Diagnostic Pointer
ME031 Special Coverage
ME076 Member rating category

Many of the new data elements may not be available in one or more of CIGNA's pharmacy reporting data sources. These include, but are not limited to the following fields:
ME035 Health Care Home Assigned flag
ME036 Health Care Home Number
ME037 Health Care Home Tax ID Number
ME038 Health Care Home National Provider ID
ME039 Health Care Home Name
ME045 Geocoded Member Address
ME051 Behavioral Health Benefit Flag

ME052 Laboratory Benefit Flag
ME053 Disease Management Enrollee Flag
ME057 Date of Death
ME059-M066
ME071 Pool Indicator
ME071 Interpreter Flag - CED
ME076 Member rating category

PC038 Postage Amount Claimed
PC049 Prescribing Physician Plan Number
PC050 Prescribing Physician License Number
PC051 Prescribing Physician Street Address
PC052 Prescribing Physician Street Address 2
PC053 Prescribing Physician City
PC054 Prescribing Physician State
PC055 Prescribing Physician Zip
PC056 Product ID Number
PC059 Recipient PCP ID
PC062 Billing Provider Tax ID Number
PC065 Coordination of Benefits/TPL Liability Amount
PC066 Other Insurance Paid Amount
PC067 Medicare Paid Amount
PC068 Allowed Amount
PC069 Member Self Pay Amount
PC070 Rebate Indicator
PC071 State Sales Tax
PC074 Route of Administration

Many of the data elements may not be available in one or more of CIGNA's dental reporting data sources. These include, but are not limited to the following fields:
DC002 National Plan ID
DC010 Member Social Security Number
DC020 National Service Provider ID
DC033 Procedure Modifier - 1
DC034 Procedure Modifier - 2
DC039 Co-pay Amount
DC042 Product ID Number
DC047 Tooth Number/Letter
DC048 Dental Quadrant
DC049 Tooth Surface

ME002 National Plan ID
ME010 Member Social Security Number
ME021 - ME027 Race, Ethnicity
ME033-034 Language

For CIGNA Behavioral Health (Org ID 7422) many of the new data fields do not apply to the behavioral health plans that CBH offers. CBH will not have available the following
MC071 DRGs
MC072 DRG Version
MC073 APC

MC074 APC Version
MC081 Capitated Encounter Flag
MC090 LOINC Code
MC091 Members PCP ID
MC108 Procedure Modifier - 3
MC109 Procedure Modifier - 4
MC112 Referring Provider ID
MC116 Withhold Amount
MC118 Referral Indicator
MC119 PCP Indicator
MC120 DRG Level
MC121 DRG Outlier
MC122 Pseudo Claims
MC126 Accident Indicator
MC127 Family Planning Indicator
MC128 Employment Related Indicator
MC129 EPSDT Indicator
MC132 Service Class
ME020 Dental Coverage
ME029 Coverage Type
ME030 Market Category Code
ME053 Disease Management Enrollee Flag
ME059 Disability Indicator Flag
ME060 Employment Status
ME061 Student Status
ME062 Marital Status
ME070 Spouse Medicare Indicator
ME071 Pool Indicator
ME074 Interpreter Flag

The company desires greater clarity on the requirements for the Product File and the Provider File. Should these be submitted just for medical data, or for pharmacy and dental data, too? For the provider and product files, should payers create separate files for dental and pharmacy data?
For pharmacy and dental plans, the majority of data elements on these two files would be not applicable.

Many of the new Provider File data elements may not be available in one or more of CIGNA's reporting data sources. These include, but are not limited to the following fields:
HD003 National Plan Id
PV002 Plan_Prov_Id
PV004 UPIN_Id
PV005 DEA_Id
PV006 License_Id
PV007 Medicaid_Id
PV011 Gender_Code
PV012 DOB_Date
PV013 Facility_Code
PV022 Taxonomy
PV030 Primary_Specialty_Code
PV033 Organization_Name
PV034 ID_Type_Code
PV035 SSN_Id

PV036 Medicare_Id
PV039 National_Provider_ID
PV040 National_Provider2_ID
PV042 Secondary_Specialty2_Code
PV043 Secondary_Specialty3_Code
PV044 Secondary_Specialty4_Code
PV045 P4P Flag
PV046 NonClaimsFlag
PV047 Used Electronic Medical Records
PV048 EMR Vendor
PV049 Accepting New Patients
PV050 Offers e-Visits
PV052 Has multiple offices
PV053 Accepts Medicaid
PV054 Medical/Healthcare Home ID
PV055 PCP Flag
PV058 Provider Class
PV059 Medicare ID
PV060 Office Type
PV061 Prescribing Provider

iNet Encryption
What are the implications regarding the current encryption utility that is used for the iNet file uploads?

All Payer Claims Database (APCD) Data Submission Guide
In the APCD Data Submission Guide there appear to be a number of data elements with population threshold levels set at 100% It is not feasible for a payer to be compliant 100% of the time on a number of these fields. Eligibility, Provider, and Claims data have their degrees of inconsistency. Even 1 non-compliant record out of a submission of 50,000 would cause a file to fail if the threshold level was set at 100% because the automated data quality process is unforgiving. CIGNA strongly recommends that the 100% threshold levels be dropped by at least 2 points. This reduction should not have a marked impact on the quality of the data but it should reduce the amount of time spent by the payers and the DHCFP investigating these few records that can never be fixed.

If you have any questions concerning these comments, please contact me at stephen.petke@CIGNA.com or 860.226.7746.

Sincerely,

Stephen Petke
Regulatory Affairs Manager